DARS
VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

~ Virginia Lifespan Respite Voucher Program ~
Application Form

Name of Primary Family Caregiver (*the person applying for respite voucher funds*)		
Name of Respite Care Recipient (*the person receiving respite services*)		
Street Address (*of both Primary Family Caregiver and the Respite Care Recipient*)		
City	**State** Virginia	**Zip**
Primary Phone Number(s)	***E-mail *(for Primary Family Caregiver)***	

Communication about the status of your request for funding will be sent primarily via email unless no email is listed.

The Primary Family Caregiver has the following relationship with the person receiving care:
☐parent; ☐court-appointed legal guardian; ☐foster parent; ☐grandparent; ☐grandchild; ☐child; ☐sibling; ☐spouse; ☐other:_____

Total number of family members in Primary Family Caregiver's household:

____Adults; ____Children (under 18 years)

How did you hear about the *Virginia Lifespan Respite Voucher Program?*
☐Center for Independent Living;
☐Social Worker;
☐Brain Injury Services Organization;
☐Hospice;
☐DARS Division on Aging; Area Agency on Aging;
☐DARS Brain Injury Services Coordination Unit;
☐Another individual or organization (please list):
_____

Required Questions:

1. **Do you live full time in the same residence as the Respite Care Recipient?** ☐Yes ☐ No
2. **Are you currently employed?** ☐Yes ☐ No
3. **Do you use non-family respite services?** ☐Yes, currently ☐No ☐Not currently but I have in the past

   If YES, please check: ☐Community Respite Organization: _____

   ☐Friends/Neighbor ☐ Church ☐Hospice

   Do you currently pay for these non-family respite services? _____
4. **Are you receiving respite services through a Medicaid Waiver?** ☐Yes ☐Waitlist ☐ No

   If YES, please select the type of waiver: ☐ID/DD ☐ EDCD ☐Other:

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Description of Voucher Funding Request (required):

Amount of voucher funding requested: **$**_____.

Date(s) and number of hours per date (estimated) you plan to use the funding for respite care services (you have 90 days from date of approval to use respite services): _____

_____

Please describe **how** you plan to use the respite voucher and **why** (Note that you *cannot* use these funds for daycare, cleaning, going to work, or any other services you are currently incurring): _____

_____

_____

Will the Lifespan Respite Voucher be used for a service you are already receiving? ☐Yes ☐ No

Respite Care Recipient Information

Name of Respite Care Recipient (*the person receiving respite services*)

Age	**Gender**	**Is the Respite Care Recipient a Veteran?**
	☐Male; ☐Female; ☐ Other	☐Yes; ☐ No

Race and Ethnicity (Check the race the recipient identifies as and then write their ethnicity beside the race)

☐African American: _____ ☐Asian: _____ ☐Caucasian:_____
☐Multiracial: _____ ☐Native American: _____ ☐Other: _____

Using the list below, please write the disability or special need in the appropriate location (if other, please specify)

Primary Disability or Special Need: _____

Secondary Disability or Special Need (optional): _____

Intellectual/Developmental Disability: Intellectual Disability; Autism; **Physical/Orthopedic/Mobility Impairment**: Multiple Sclerosis; Muscular Dystrophy; Cerebral Palsy; **Sensory/Communication Impairment**: Blind/vision impaired; Deaf/ hard of hearing; **Mental/Emotional/Psychosocial Impairment**: Mental Illness; Mood/Personality Disorders; **Degenerative Neurological Impairment**: Dementia/Alzheimer's; Parkinson's; ALS; **Neurological Impairment (nondegenerative)**: Stroke; Traumatic Brain Injury; Spinal Cord Injury; **Medically Fragile/ Frail Elderly**; **Other**

***Documentation of the Respite Care Recipient's condition/disability must be included in this application form or it cannot be processed or approved. Documentation cannot be more than two years old (2013-2015)**

Examples of Acceptable Documentation of Condition / Disability: *(Please limit documentation to one page)*

- Physician/Psychologist Written Diagnosis of Disability/Condition: 1 page
- Social Security Administration Letter of Determination for Disability Benefits: 1 page
- School District Special Education Eligibility/Individualized Educational Plan Cover Sheet/Sign off Sheet: 1 page
- Early Intervention Eligibility/Individualized Family Service Plan Cover Sheet/Sign-off Sheet: 1 page
- Vocational Rehabilitation Statement of Qualifying Disability: 1 page
- Long-term Disability Insurance Statement of Eligibility of Benefits: 1 page
- Medicaid Eligibility/Medical Assistance Eligibility Forms: 1 page

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Acknowledgements

Primary Family Caregiver: Please read and initial *each* item below. Sign and date form before submitting the application to the Virginia Department for Aging and Rehabilitative Services (DARS).

_____I attest that I am the Primary Family Caregiver of the Respite Care Recipient listed in this application form and that I reside full-time in the same residence with the Respite Care Recipient in the Commonwealth of Virginia.

_____I attest that I have read and understand the DARS *Virginia Lifespan Respite Voucher Program* application procedures. I understand my signature below authorizes a release of information for program purposes only.

_____I understand that the funds I receive from the *Lifespan Respite Voucher Program* are solely for services provided to the Respite Care Recipient listed on this application and that these funds cannot be used for any other purpose. I understand that if I have existing government debt, I may not receive my entire refund.

_____I acknowledge that I am responsible for hiring an individual respite care provider or organization and arranging for payment for respite services received. I understand that I will be reimbursed an amount not to exceed the amount approved by DARS on my ***Application Form***. I understand that I am responsible for any difference in the amount approved and the amount paid by me, if any.

_____I will submit a ***Reimbursement Form*** within 30 days of the date of purchase and delivery of respite services. I understand that any unspent portion of my respite voucher may be forfeited if I have not made prior arrangements for use of my respite voucher funds by this deadline. I agree to complete and return the required ***Satisfaction Survey***. *

_____I understand that if I elect to hire my own individual respite care provider, I am responsible for negotiating the rate of pay with the identified respite services provider. I am also responsible for providing any training or instruction the respite care provider(s) of my choice may need to provide services to the respite care recipient.

* Final claims for reimbursement cannot be processed or paid until the ***Satisfaction Survey*** and the ***Reimbursement Form*** are received by DARS.

The Virginia Department for Aging & Rehabilitative Services (DARS) administers the *Virginia Lifespan Respite Voucher Program* to provide short-term funding for respite care services, but does not provide these services directly or indirectly. I attest that the information included in this ***Application Form*** is true and accurate to the best of my knowledge. I understand that falsification of information will result in termination of services.

Signature:_____

Applicant (*Primary Family Caregiver*) **Date**

Print Name:_____

Applicant (*Primary Family Caregiver*)

Please mail/fax or scan and email this form with the required documentation of disability or special need to:

Virginia Lifespan Respite Voucher Program, ATTN: Mary Strawderman,
Virginia Department for Aging and Rehabilitative Services (DARS),
8004 Franklin Farms Drive,
Henrico, Virginia 23229;
or Fax to 804/662-7663; or E-mail to mary.strawderman@dars.virginia.gov.

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